Who Wants To Live Forever?

Identifying and Working Through Capacity Issues in the Age of De-Aging

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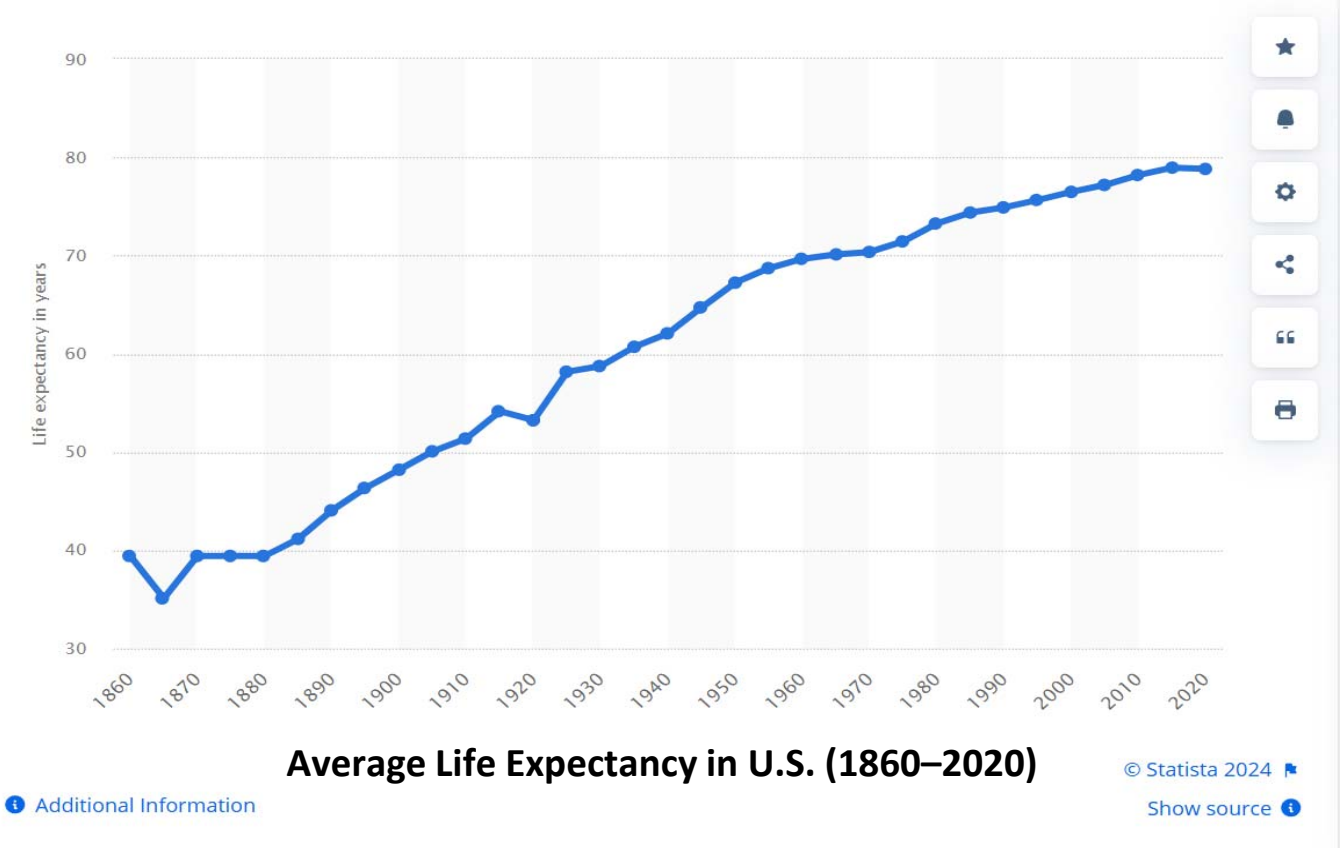
The Prelude



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Other "Fun" Stats about Cognitive Impairment

- ~ 2/3 of Americans experience some cognitive impairment, at an average age of ~70 years old
- Lifetime risk of dementia for women is 37% and for men is 24%, with mean onset ages of 83 and 79
- Women live an average of 4.2 years with mild cognitive impairment (MCI), and an average of 3.2 years with dementia; men live an average of 3.5 years with MCI vs. 1.8 years with dementia
- Significant racial/ethnic and educational disparities in dementia
- Advantaged groups have delayed impaired, compressed to the very end of life, whereas disadvantaged groups tend to have younger onset, higher risk, and more years impaired
- **TL;DR — there is an increasingly good chance that we and our friends, family, and clients are going to live long enough to experience some form of cognitive impairment**

Theme and Goals re Today's Discussion

- **Theme**: As medical science extends the average lifespan, there will be more opportunities for mental-capacity issues to arise and negatively impact our lives. So let's be ready to spot and address those issues with honesty, transparency, and dignity
- **Goals**:
  - Explore why capacity is important and what are the relevant legal guideposts
  - Learn to distinguish between normal aging and signs of serious cognitive illness/impairment;
  - Familiarize ours with tests and tools for diagnosing cognitive/capacity issues; &
  - Review techniques for communicating with and about aging or impaired clients

Outline re Today's Discussion

I. Why Is Capacity Important To Think About?
   A. Consequences
   B. Legal contexts/Issues implicating capacity & related issues
   C. Brief Review of Governing Law and Relevant Tests

II. Spotting Potential Capacity Issue (i.e., Distinguishing Ordinary Cognitive Decline from Cognitive Impairment and Dementing Illnesses)

III. Ways of Thinking Through Capacity Issues
   I. Duty
   II. Communicating
   III. Diagnosing and Bracing for Claims re Capacity

IV. Hypotheticals & Questions

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Consequences of Not Thinking Through Capacity Questions

- **Civil and (possibly) criminal consequences, depending on your involvement**
  - **Civil**
    - Invalidation of legal instrument (either inter vivos or testamentary)
    - Damages (restitution, consequential damages, and possibly enhanced remedies such as attorneys' fees, double damages, and punitive/exemplary damages)
    - Other injunctive relief to remedy harm that can't be remedied by damages
  - **Criminal**
    - Liability for elder abuse or dependent-adult abuse
    - Liability for other criminal causes of action (e.g., fraud, theft/larceny, embezzlement

Legal Contexts Implicating Capacity & Related Issues

- Signing testamentary instrument (will or trust)
- Signing inter vivos instrument
  - e.g., real-estate sale purchase-and-document, quitclaim deed, loan, etc.
- Other estate-planning documents
  - E.g., power of attorney, AHCD, general assignment
- Imposition of a conservatorship of the person and/or estate
- Decisions to receive or refuse medical treatment
- Decision to get married

Brief Review of Governing Law & Relevant Tests

- **What is "Capacity"?**
  - Capacity or ability to understand; not whether the person *actually* understands, but whether they *have the ability* to understand.
  - Judged at the point in time when the act/decision was done (e.g., at time of execution).
- **Measured on a "Sliding scale"**
  - "Mental capacity can be measured on a sliding scale, with marital capacity requiring the least amount of capacity, followed by testamentary capacity, and on the high end of the scale is mental capacity required to enter into contracts." *In re Marriage of Greenway* (2013) 217 Cal.App.4th 628, 639.
  - In other words, the more complex the decision, the more capacity must be demonstrated

Brief Review of Governing Law & Relevant Tests

- **Kinds of Capacity (least to most difficult):**
  - **Capacity to Marry**
    - Lowest amount of capacity required (*Marriage of Greenway*)
    - Even appointment of conservator doesn't affect one's capacity to marry (Prob. Code § 1900)
  - **Testamentary Capacity**
    - "Exceptionally low standard" (*Marriage of Greenway*)
    - Requires that testator (1) understand nature of testamentary act, (2) understand and recollect nature of assets, and (3) remember and understand relationships to family members and others whose interests are affected by will (Prob. Code § 6100.5)
    - Rebuttable presumption in favor of testamentary capacity (Prob. Code § 6100(a).) Must be rebutted by preponderance of evidence. (*Andersen of Hunt* (2011) 196 Cal.App.4th 722, 7300.)

Brief Review of Governing Law & Relevant Tests

- **Kinds of Capacity (least to most difficult) (cont'd):**
  - **Capacity to Give Informed Medical Consent**
    - Capacity to give informed medical consent requires patient to be able to do all of the following:
      a) Respond knowingly and intelligently to queries about medical treatment;
      b) Participate in the treatment decision by means of a rational thought process; and
      c) Understand: (1) nature and seriousness of issue, (2) nature of treatment recommended, (3) probable risks and benefits of treatment/non-treatment, and (4) nature, risks, and benefits of alternatives. (Prob. Code § 813.)

Brief Review of Governing Law & Relevant Tests

- **Kinds of Capacity (least to most difficult) (cont'd):**
  - **Contractual (a.k.a. "Decisional") Capacity**
    - Presumption in favor of decisional capacity (Prob. Code § 810(a))
    - Rebutted by proving deficits in mental function "and evidence of correlation between… deficits and the decision or acts in question": (1) alertness/attention; (2) information processing,
      (3) thought processes, and (4) ability to modulate mood/affect (Prob. Code § 811)
    - Person lacks capacity unless they have ability to communicate their decision and to understand and appreciate: (1) rights, duties, and responsibilities affected by decision, (2) probable consequences for decisionmaker and other affected persons; and (3) risks, benefits, and alternatives (Prob. Code § 812)
    - "Functional" capacity distinguished: ability to handle finances or resist fraud & undue influence (e.g., conservatorship-style inquiry)

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Issues Affecing Capacity, Generally

Issues that may influence capacity/mentation:

- The presence of mental illness
  - Psychotic disorders
  - Affective disorders
  - Major neurocognitive disorders/dementia
- Delirium
- Disability
- Vulnerability
- Personality factors

Normal Aging

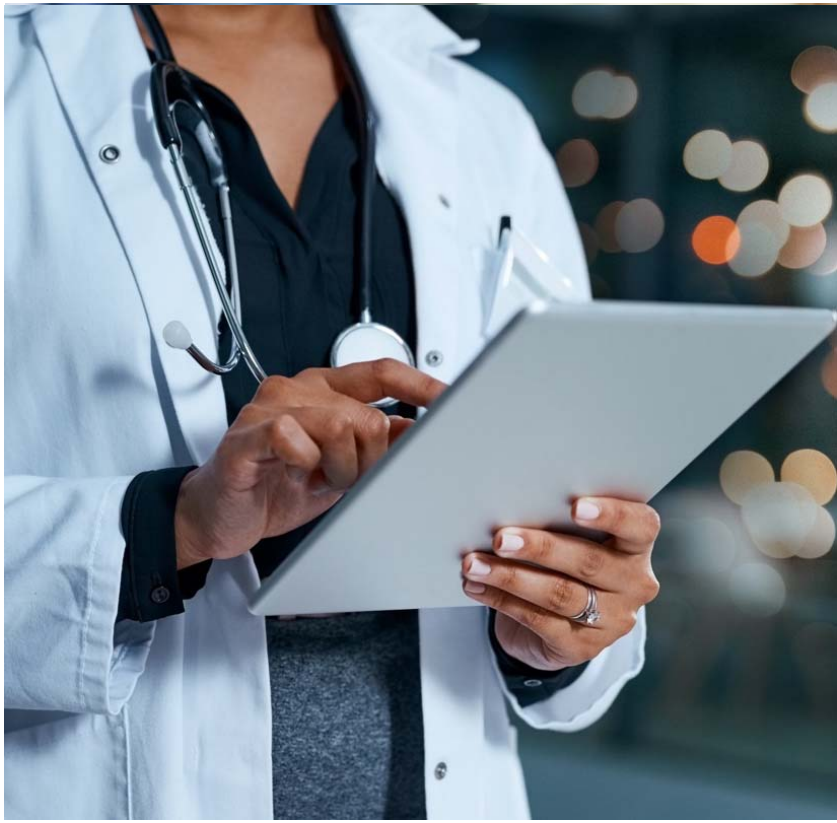
- The expected cognitive and behavioral changes associated with normal aging
- A function of the skills and knowledge base that is overlearned and practiced
- Patients usually retain insight into these losses
- Functions decline linearly, e.g., reduced processing speeds or attention spans, mild executive dysfunction, visuospatial difficulties, and reduced language skills
- Though present, these factors do not limit engagement in independent, purposeful, and self-preserving behavior
- Retained ability to function independently

Mild Cognitive Impairment (MCI)

- A decline in cognition involving one or more cognitive domains (e.g., orientation, language, executive function, complex attention, memory, perceptual-motor, and/or social cognition) **WITHOUT** interference with daily function and/or independence.
  - Minor Neurocognitive Disorder (DSM-5) has criteria, but essentially interchanged by clinicians
  - Amnestic MCI versus non-amnestic MCI

Mild Cognitive Impairment (MCI)

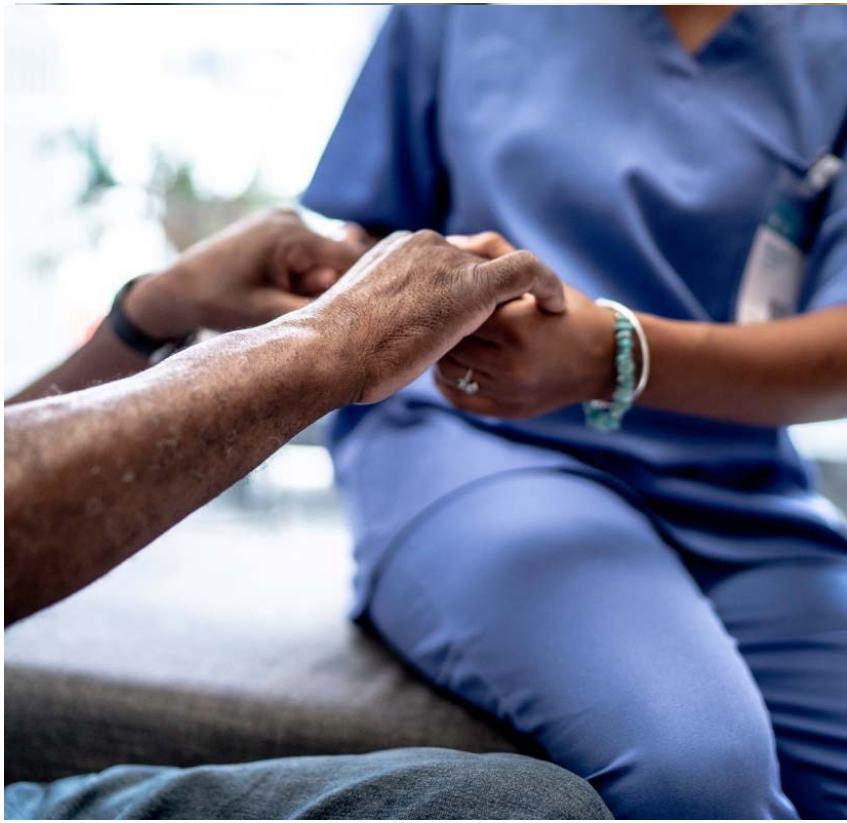
- MCI can be a precursor to dementia
  - The estimated risk of conversion is between 10–15% annually (Petersen RC, 1999; Larrieu S, 2002)
  - Risk factors for progression include age, neuropsychiatric symptoms, cerebrovascular disease, vascular risk factors and APOE allele.
- Presence of preclinical imaging or biomarkers of specific dementia syndromes

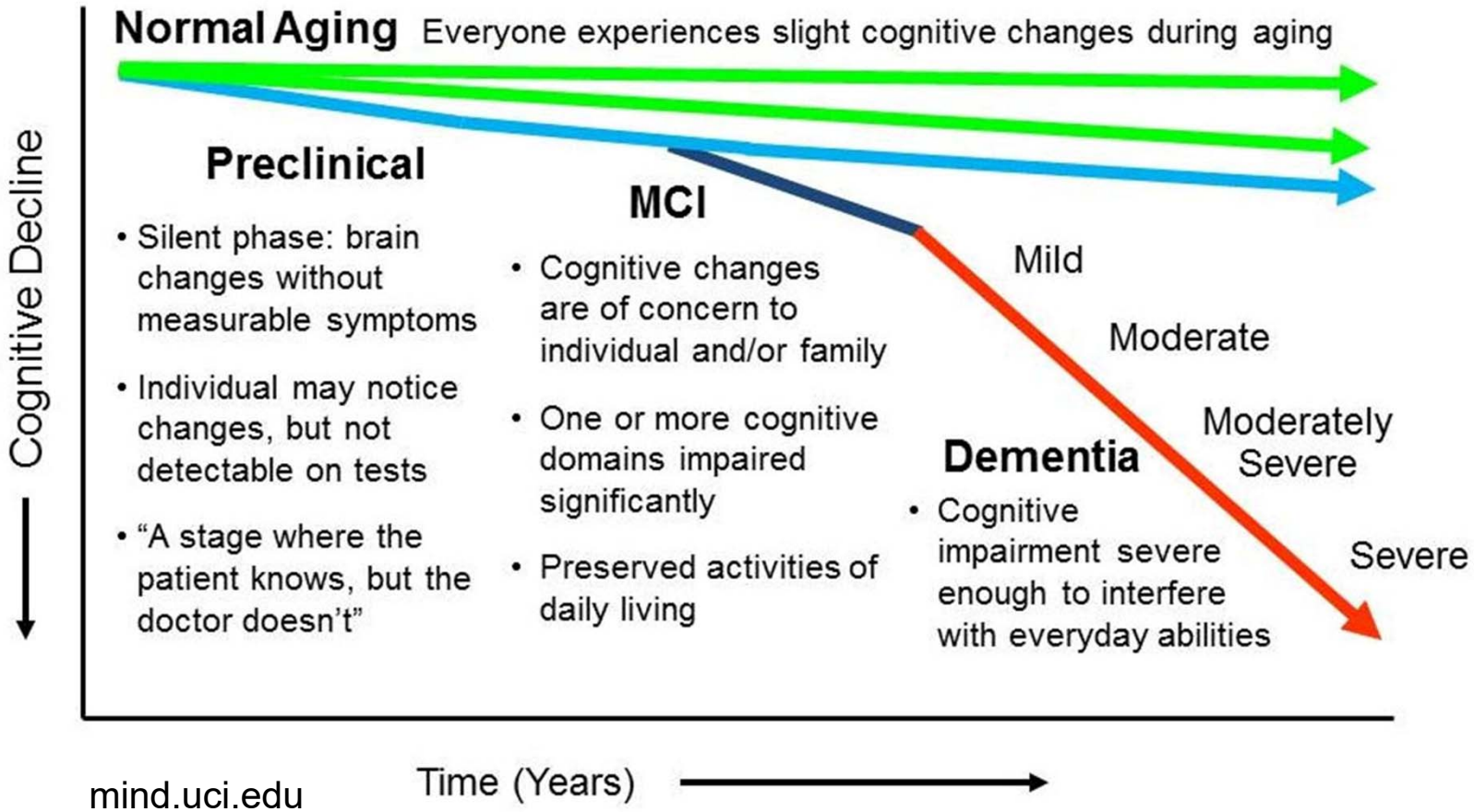


Dementia

- A decline in cognition involving one or more cognitive domains (e.g., orientation, language, executive function, complex attention, memory, perceptual-motor, and/or social cognition) and loss of functional dependence* from a previously established baseline (DSM-5, 2013)
  - DSM-5: Major Neurocognitive Disorder

*i.e. activities of daily living (ADLs) and instrumental activities of daily living (IADLs); loss must be due to cognitive dysfunction, NOT physical dysfunction.

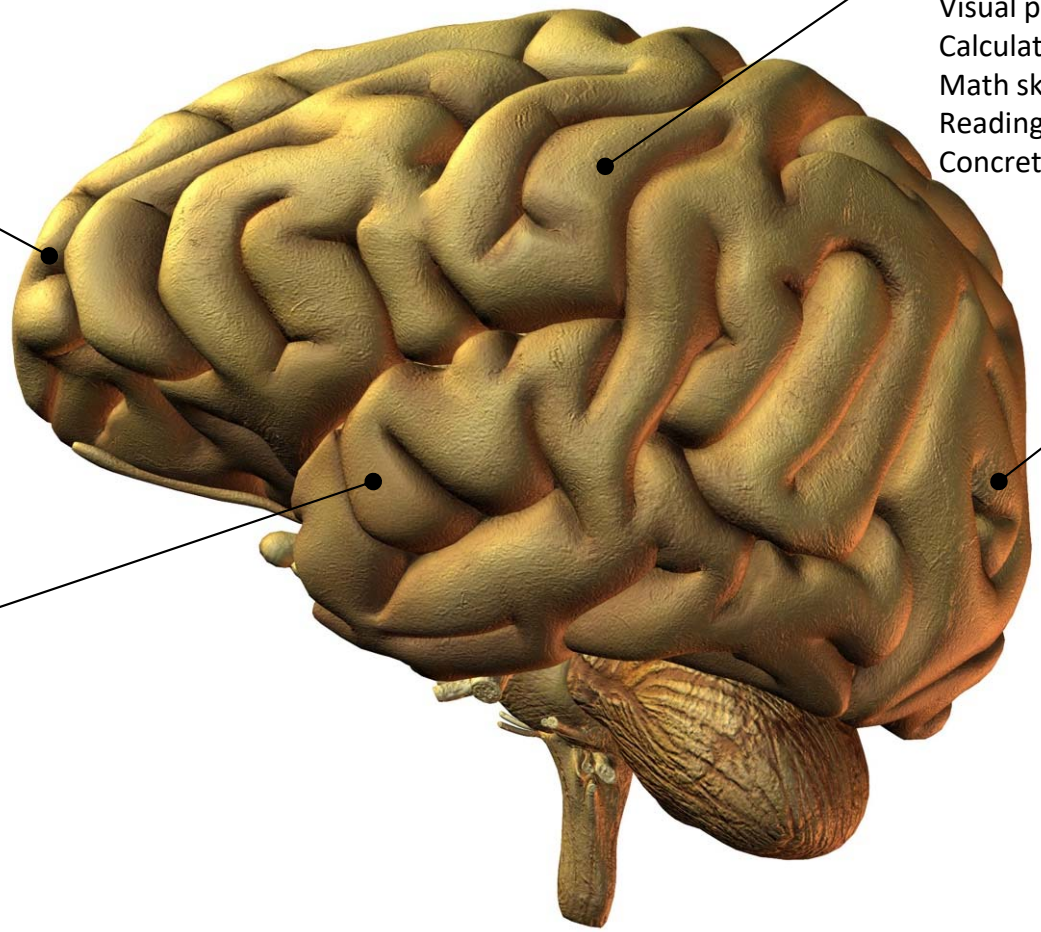



Normal Aging
Everyone experiences slight cognitive changes during aging
Preclinical
• Silent phase: brain changes without measurable symptoms
• Individual may notice changes, but not detectable on tests
• "A stage where the patient knows, but the doctor doesn't"
MCI
• Cognitive changes are of concern to individual and/or family
• One or more cognitive domains impaired significantly
• Preserved activities of daily living
Dementia
• Cognitive impairment severe enough to interfere with everyday abilities
Mild
Moderate
Moderately Severe
Severe
Cognitive Decline
Time (Years)

mind.uci.edu

Frontal Lobe
Planning & organizing
Problem solving & decision making
Attentional tasks
Personality
Controlling behavior, emotions & impulses
Planning
Judgment
Initiation

Parietal Lobe
Spatial perception
Visual perception
Calculations
Math skills
Reading
Concrete concepts



Occipital Lobe
Receive & process visual information
Perception of shapes & colors

Temporal Lobe
Memory
Orientation
Information retrieval
Language understanding
Language expression
Organization and sequencing
Feelings, emotions
Fear
Abstraction

Dementia: Incidence, Prevalence and Trends

- Worldwide: estimated 50 million people living with dementia (World Health Organization, 2017)
  - United States: estimated 6.9 million people living with Alzheimer type dementia (Alzheimer's Association, 2024)
- By 2030, worldwide projected estimate of 82 million people w/ dementia
  - Estimate of 139 million worldwide by 2050 (WHO, 2024)
- Trend: annual growth of about 9.9 million new cases, and increasing
  - Of these cases, Alzheimer disease is the most common cause, worldwide
    - 1 in 10 Americans over the age of 65 has Alzheimer disease
    - 1 in 3 Americans over the age of 85

alz.org

Dementia: Causes

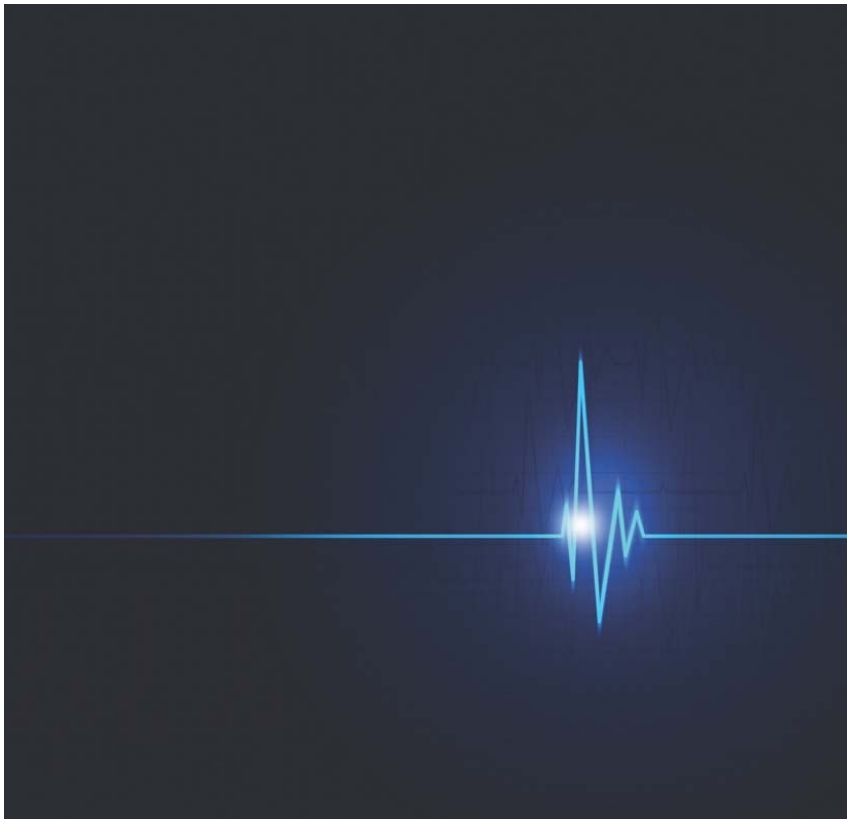
- Alzheimer disease (AD): 60–80%
- Vascular dementia (VaD): 10–15%*
- Dementia with Lewy Bodies (DLB)/Lewy Body Dementia (LBD): 5–10%
- Frontotemporal Dementia (FTD): 2–5%
- Parkinson Disease Dementia (PDD): 2–5%
- HIV-associated Dementia
- Creutzfeldt-Jakob Disease
- Huntington Disease

- Posterior Cortical Atrophy (PCA)
- Progressive Supranuclear Palsy (PSP)
- Corticobasal degeneration (CBD)
- Multisystem Atrophy (MSA)
- Alcohol-related Dementia
- Chronic Traumatic Encephalopathy (CTE)
- Normal Pressure Hydrocephalus (NPH)

*30–50% of dementia cases are mixed dementia (most being VaD plus AD)

Clinical Overview: Alzheimer disease

- Late onset versus early onset
- Time course: Slow onset and gradual progression over months or years (Arvanitakis Z, 2019)
  - 3–4 point decline in MMSE annually (Adak S, 2004)
  - More rapid decline indicates more progressive illness (Schmidt C, 2011)
- Avg. life expectancy after a diagnosis: 8–10 years
- Common causes of mortality:
  - Dehydration and malnutrition
  - Infection: UTI and URI, including aspiration pneumonia

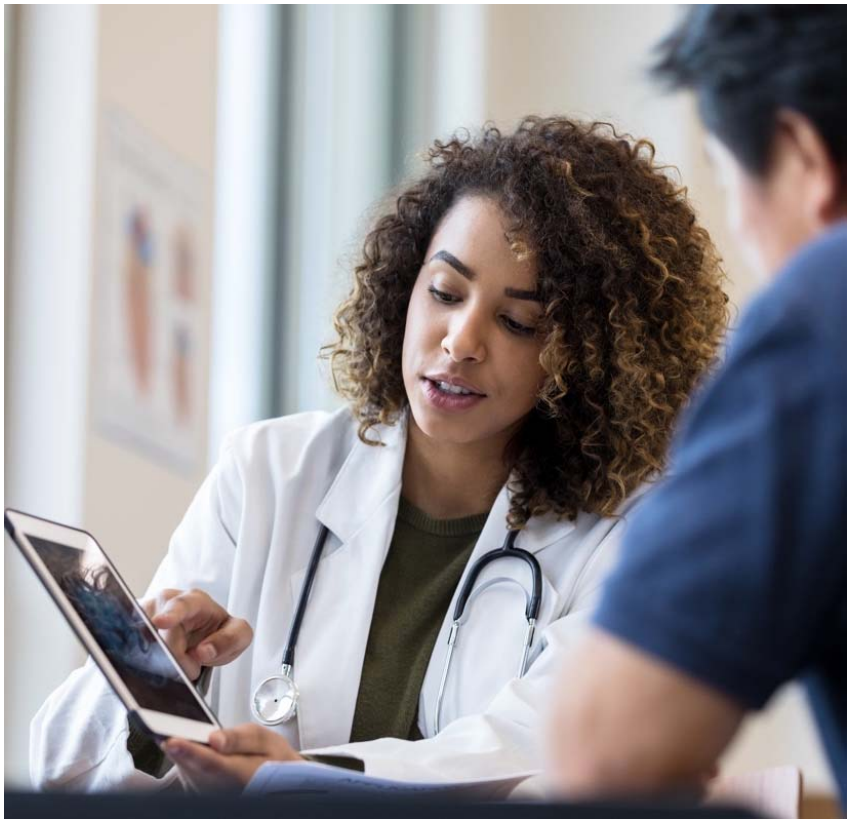


Clinical Overview: Alzheimer disease

- Cognitive features: (typically) memory loss plus one other cognitive domain (orientation, language, executive function, complex attention, perceptual-motor, and/or social cognition)
- Associated with behavioral disturbances as disease progresses
  - Earlier presentation of behavioral symptoms, especially agitation, psychosis, and/or agitation associated with more progressive decline

Clinical Overview: Vascular Dementia

- Second most prevalent dementia, often as mixed-dementia
- Pathology: ischemic or toxic injury to regions of the brain implicated in various cognitive functions
- Both stepwise (common) and gradual progression (less common)
- Variable course, dependent on vessels involved, future modification of risk factors and disease recurrence
- Temporal relation between vascular event and onset of cognitive impairment



Clinical Overview: Vascular Dementia

- Common presentation: abrupt onset, stepwise decline, history of risk factors, focal neurologic signs
- Cognitive features: impairment in executive function and processing speed
  - Wide variation in the cognitive deficits due in large to heterogeneity in vascular disease
  - Memory deficits tend to be spared (Graham NL, 2005)
- Look for vascular depression or vascular parkinsonian symptoms
- Symptoms may include apathy; abulia (lack of will or initiative); aphasia (word-finding difficulty); pseudobulbar affect (emotional incontinence, sudden uncontrollable and inappropriate laughing or crying)
- Outlook: cognitive impairment may improve as part of the stroke recovery process: brain rehabilitation, speech therapy, occupational therapy, cognitive therapy

Clinical Overview: Lewy Body Dementia

- Cognitive features: visuospatial and executive dysfunction
- Association with:
  - Fluctuations in alertness (spontaneous, episodic)
  - REM sleep behavior disorder: erratic flailing, jerking, or thrashing at night (Ferman, 2011)
  - Visual hallucinations
  - Parkinsonism: milder and bilateral (versus typical PD); later in disease course, bradykinetic movements, rigidity and gait disturbances
    - Neuroleptic sensitivity (can even occur in the absence of baseline parkinsonian symptom; (suggestive feature, not core to illness) (McKeith I, 1997)
- Time course: Slow onset and gradual progression over months or years (Arvanitakis Z, 2019)
  - 5.8 point decline in MMSE annually (Olichney JM, 1998; Ballard C, O'Brien J, 2001)
- Average life expectancy after onset of cognitive dysfunction: 7.7 years (Williams MM, 2006)

Clinical Overview: Parkinson Disease Dementia

- Cognitive features: visuospatial and executive dysfunction; attentional deficits
  - Similar cognitive profile to DLB (Noe E, 2004)
  - Less prominent memory and/or language deficits as compared to AD
- Association with:
  - Complex visual hallucinations
  - Paranoid and persecutory delusions
  - Depression
  - Sleep disturbances: REM sleep behavior disorder, sleep fragmentation, nightmares
  - Parkinsonian symptoms
- Time course: cognitive symptoms 5–8 years after onset of Parkinson motor symptoms (late in clinical course)
- Average life expectancy after onset of cognitive dysfunction: 4–6 years (Larsson V, 2018)

Clinical Overview: Frontotemporal dementia

- Includes “classic” behavioral variant FTD (bvFTD) (most common)
  - Less common: primary progressive aphasia (nonfluent variant, nfvPPA), semantic variant (svPPA), and logopenic aphasia
- “Early onset” dementia: usually between late 40s and early 60s
- Sporadic (60%) versus familial (mutations in MAPT, GRN, C9orf72 genes)
- No evidence of acetylcholine system involvement (Mendez, 2007)
- Time course: Slow onset and gradual progression over months or years
- Average life expectancy after onset of cognitive dysfunction: 7 to 13 years (Onyike, 2013)

Clinical Overview: Frontotemporal dementia

- Cognitive features: (bvFTD) executive dysfunction, personality changes
- Association with:
  - Behavioral disinhibition: limited social graces, utilization behaviors, shoplifting, hypersexuality
  - Apathy: indifference, loss of motivation, lack of attention to hygiene/care
  - Loss of empathy: inability to read emotional cues, lack of reciprocal or expected emotions
  - Dietary changes: hyperorality, odd food cravings, pica, binge eating, use of alcohol, tobacco and/or illicit drugs
  - Behavior compulsions: stereotyped or ritualistic behaviors (may mimic OCD)
    - Checking, hoarding, cleaning, hand washing
  - Behavioral and personality rigidness
  - Limited/poor insight

Behavioral and Psychological Symptoms in Dementia (BPSD)

- Associated behavioral symptoms and disturbances secondary to a dementia syndrome—including but not limited to psychosis, agitation, depression, and anxiety
- Classically, “sundowning” behavior, where behavioral disturbances peak later in the day
  - May be related to a circadian rhythm disturbance
- Increased burden on caregivers, leading to increased risk of hospitalization and eventual institutionalization
- Distressing for the patient, even ones with limited insight
- Reduced quality of life for all who are involved
- Flare-ups can be due to issues such as disease progression, pain, sleep disturbances, delirium, medication AE, medication withdrawal

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Whose Duty Is It, Anyway?

- Potential concerns about capacity issues? Before saying something, ask yourself 2 Qs:
  - Do you or your client owe any legal duties to person who may have capacity issues (or to someone who is dealing with that person)?
    - Fiduciary? (e.g., successor trustee, attorney, conservator, others?)
    - Contractual?
    - Mandatory reporter (e.g., re elder abuse)?
      - W&I C. § 15630 (amended by AB 1417)
  - Step two: what about moral duties?
    - Lots of gray area, where legality/validity may depend on a jury and their sense of fairness and justice

Challenges in Communicating with Older/Impaired Persons

- Time management and time pressures
- Multiple and complex issues
  - Medical
  - Psychobehavioral
  - Social
  - Legal
- Balancing autonomy/independence with paternalism/directives
- Competing interests: individual vs societal
- Resource allocation/availability
- Ageism
- Delivering “bad news”
- Managing conflicts

Best Practices re Speaking *With* Older/Impaired Persons

General Best Practices

- Assessment is facilitated by being aware of the scope and needs of the older population; a one size approach does not work
  - Calibrate based on what we think the problem may be, so use a different approach for temporary amnesia vs. degenerative dementia
- Assume a client is capable and competent until or unless assessed otherwise
- Letting clients talk for a few minutes conveys caring, helps understanding and evokes a sense of partnership and collaboration
- Try to help them see how diagnostics and/or treatment can be in their best interest
- If they cannot or will not act in their own rational self-interest, seek help with family, loved ones/trusted individuals, or other appropriate third parties (e.g., A.P.S.)

Other Tips for Communicating With Older/Impaired Persons

Sound

- Minimize extraneous noise, frequent interruptions, phone rings
- Ensure hearing aids are utilized
- Personal amplifier (e.g. Pocketalker)
- Remove mask to enunciate and ensure clarity
- Speak clearly but not necessarily slowly or loudly
- Speak to side of good hearing

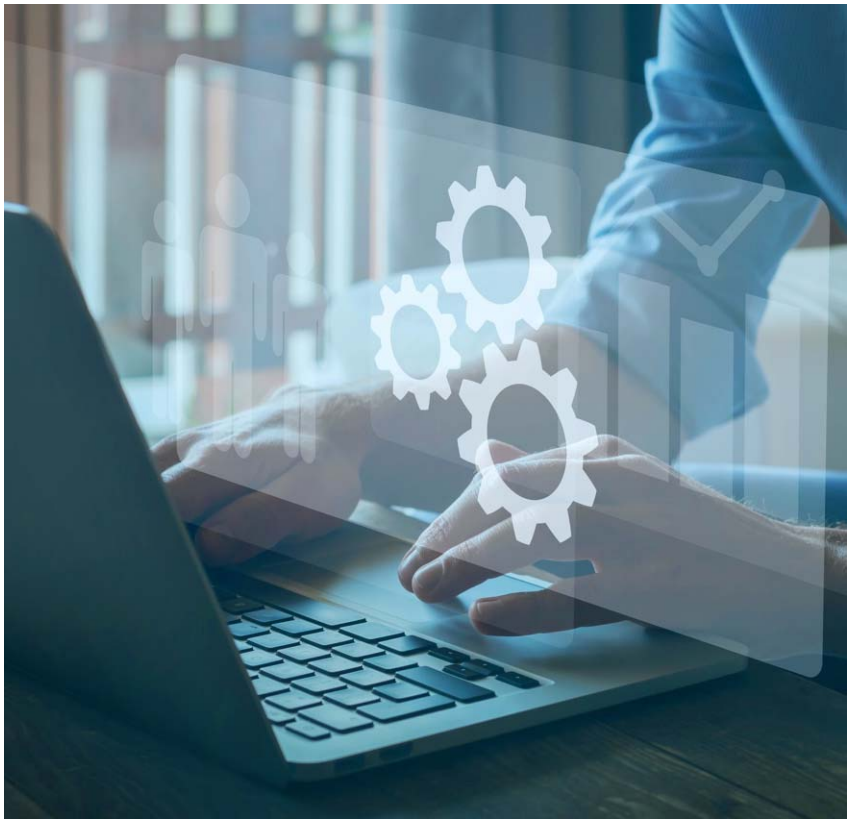
Visuals

- Visible signage
- Literature, handouts, tests: large print, legible

Best Practices re Speaking ***About*** Older/Impaired Persons

General Best Practices

- Involve key family members, when possible (transparency breeds trust)
- Involve the affected person, too, if possible
- Give decisionmakers access to information (medical information, legal options)
    - If that information is not yet available or organized, try to gather it (e.g., run diagnostic tests, speak with probate attorney about situation, etc.)
- Give them time and space to process difficult news and work through options



Diagnosing and Bracing For Claims re Capacity

What can we do if an individual is willing to work with you in diagnosing or ruling out capacity issues?

- Diagnostic mental-status and/or neuropsychiatric exam
- Gather informal evidence to buttress position on capacity
- Work with independent attorney to complete certificate of independent review (primarily to rebut claims re undue influence)
- No-contest clause and inclusion of new/add'l instruments (must stand to lose, though)

Diagnostic/Clinical Exam re Capacity Issues

Include family members and other collateral sources of information

- **History of present illness**
  - Duration of symptoms
  - Timeline of cognitive symptoms
  - Associated medical and/or psychiatric symptoms
  - Behavioral changes
  - Changes in functionality
  - Participation in daily activities
  - Exposure to head injury, heavy metals/organophosphates
- **Medical history**
  - Includes current medications
- **Family history**
  - Dementia, neurologic disease, cardiovascular disease or psychiatric illness
    - Age of onset
- **Psychiatric history**
  - History of depression or other affective disorders
  - Substance abuse history
- **Social history**
  - Educational attainment
  - Vocational history
  - Hobbies/activities

Diagnostic/Clinical Exam re Capacity Issues

- Physical exam
  - Focal neurologic signs or deficits
  - Pertinent systemic signs
- Laboratory examination
  - Routine: CBC, CMP, TSH, B12, folate
  - If indicated (or risk factors): RPR or VDRL, HIV
- Neuroimaging
  - Structural neuroimaging with either a noncontrast head CT or MRI
- Psychometric testing
  - “Bedside” exams
  - Formal neuropsychological battery or profile

Clinical Exam and Evaluation

- **Specialized testing**
  - Consider in younger patients, rapidly progressive illness or uncertainty in diagnosis that may equivocate treatment plan
    - Genetic testing (both direct-to-consumer and clinical)
      - APOE
    - Lumbar puncture
      - CSF analysis (inflammatory, infectious)
    - Biomarkers
      - Total and phosphorylated tau analysis
      - Aβ protein
    - EEG
    - Advanced neuroimaging
      - PET-FDG (positron emission tomography with 18-F fluorodeoxyglucose)
      - SPECT (single-photon emission computed tomography)
      - Amyloid PET
      - Tau PET
    - Tissue biopsy

Psychometric Testing

To test or not to test?

- Following "bedside" screeners (MMSE, MoCA, etc.), can consider formal neuropsychological testing
  - Battery of assessments of cognitive and behavioral functions, e.g:
    - Wechsler Adult Intelligence Scale (WAIS) (intelligence, fund of knowledge)
    - California Verbal Learning Test (memory)
    - Boston Naming Test (language)
    - d2 Test of Attention (attentional tasks)
    - Rey-Osterrieth Complex Figure (visuospatial and executive function)
    - Test of Variables of Attention (TOVA) (executive function)
    - Trail-Making Test (TMT) or Trails A & B (executive function)
    - Dementia rating scales
    - Depression rating scales
    - Personality inventories
- Limits: expense (not covered by all insurers), cultural (in)sensitivities, language limitations, in-person testing, cooperation and patience, mental stamina, availability of qualified providers

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QUESTIONS?

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Hypothetical #1

A 62 YO widowed woman is referred to your practice due to recent changes in behavior that have become increasingly concerning by her family. Her husband of 29 years died two years ago, and over the past year, she has been socializing more with younger peers at work. Her son is worried she has been taking on some of their "bad habits," such as smoking cigarettes and only wanting to eat fast-food hamburgers (though she was a vegetarian most of her life). She was recently caught twice a local market for taking items from the shelves and placing them in her bag without intending to pay. She sees nothing wrong with her behaviors, and is seemingly unaffected by her son's emotional breakdown during the course of describing his concerns that "something's wrong." Son eventually files petition for appointment of a probate conservatorship of woman's person and estate and you are appointed as CAC for woman.

How might we defend against conservatorship petition?

Hypothetical #2

A 72 YO male conservatee signs a will disinheriting his ne'er-do-well son who is unemployed and has drug issues and leaving everything to daughter, who visits him at nursing facility every week, assists with physical therapy, and generally treats him well. Son claims conservatee lacked capacity based on establishment of conservatorship of the estate and person over conservatee and based on the fact that he sometimes had significant memory issues.

How might we determine whether conservatee retained capacity to execute?

Case #1

Mr. G has a longstanding history of chronic schizophrenia. He has lived in a board and care facility for the past 30+ years where his basic needs are met, and was once LPS conserved by his eldest brother. Conservatorship followed a series of recurrent hospitalizations in the setting of medication nonadherence. At baseline, Mr. G entertains a delusional thought system that centers around government conspiracies and subversive tactics used by the Illuminati. Additionally, he describes a singular voice speaking to him, making deprecatory statements. One evening he is brought by EMS to a local emergency room due to severe lower quadrant abdominal pain, nausea, vomiting and fever. He is found to have acute appendicitis and there is immediate concern for rupture and resultant sepsis. The treatment team recommends an emergent appendectomy. The surgeon explains the surgery to Mr. G, but she is worried about Mr. G's mental health concerns and consequently, his medical decision-making capacity. Specifically, she questions his capacity to consent to treatment. Mr. G is able to state he wishes to proceed with surgery and understands if he does not do so, his well-being and livelihood may be jeopardized. He states he does not want an infection and wants the pain to stop. Without detailed specifics, he is able to repeat back some of the basic risks of surgery, but admits that the voice is distracting him and calling him "an idiot" for coming to the emergency room because the Illuminati use the hospital as a covert interrogation prison. How should his surgeon proceed?

Case #2

Mrs. W is an 84 year-old widow who comes to your office asking to rewrite her survivor's trust. Despite receiving very clear directions to your office, she arrives about 2 hours late, stating she was sent the wrong building and was sitting in another office until the receptionist there helped guide her to your building. Though you introduce yourself and state your name, she has a hard time repeating it back, often times referring to you by the wrong name. Mrs. W reports having three daughters, Anabel, Marie and Kira; she is able to state their ages, where they each live and the names of their partners and children. The original survivor's trust equally divided the estate between the three children. She reports her assets accurately, including the relative market value of her home, cash assets and a retirement account set up by the school district she was employed at for 32 years. She wishes to rewrite the trust to completely exclude her daughter Kira, namely, according to Mrs. W, because Kira and her partner, Ben, have been coming into Mrs. W's home at night to take some of her various items, some of them insignificant in value, such as shampoo or bananas. As such, Mrs. W wishes to immediately disinherit her daughter, Kira. Can you identify any concerns?

Case #3

Mr. R, a 72 year-old client of yours who you historically helped form an estate plan returns to create amendments due to changes in his financial situation and family dynamics. Having known him for many years, you know he was treated for depression in the past. When you see him today, accompanied by his daughter, he appears more subdued and apathetic; he is simply not his charismatic old self. His daughter reports he has become increasingly more disengaged, forgetful and "lazy." His laziness, she reports, is mainly his reluctance to shower or brush his teeth. This seemingly started around the time he was forced to retire as a CPA due to his inability to keep up with the new computerized financial software implemented by his firm. On exam, the gentleman appears much thinner than you recall with evidence of muscle wasting. He is less conversant than he previously was, with much in way of latency when discussing the reason he is in the office today. He is unaware of most of the issues brought up by his daughter, and seemingly indifferent. By his report, he continues to work part-time as a CPA. How would you proceed?

Case #4

Recently, Mrs. B decided to prepare her will. She and her late husband were exceptionally wealthy. The two were married 49 years and never had any children. She wished to make bequests to her siblings' children, if they needed it. It had been many years since she had seen them or even spoken to them because of the pandemic. She did speak with Silvester, a nephew that regularly updated her on his cousins' status. He told her that he did not have their current phone numbers or contact information, but he could communicate her wishes to them via social media. He falsely claimed that his cousins were financially well off and only he was in need of financial support. The reality was that some of his cousins were struggling financially, one was dealing with an extensive amount of medical debt that he was unable to pay off due to disability, while another was going through a tumultuous and costly divorce. Based on Silvester's statements, Mrs. B provided for a $300,000 bequest to him; her other nieces and nephews were left out entirely. The balance of her estate was left to a charity she long supported. Can you identify any concerns?

Case #5

Recently, Mrs. B decided to prepare her will. She and her late husband were exceptionally wealthy. The two were married 49 years and never had any children. She wished to make bequests to her siblings' children. It had been many years since she had seen most of them, with the exception for Silvester, as he lived locally and would oftentimes come over to see her, spend the holidays, or help her with a variety of personal matters. He often updated her of his cousins' whereabouts and lives, sharing pictures from a reunion they just had, the first of its kind. Silvester and his aunt were close, as his mother was Mrs. B's youngest sister who died at a young age in a tragic car accident. Based on their relationship, Mrs. B provided for a $300,000 bequest to Silvester and $20,000 to each of her other six nieces and nephews. The balance of her estate was left to a charity she long supported. Can you identify any concerns?

Recommended Reading and Resources

Arvanitakis Z, Shah RC, Bennett DA. Diagnosis and Management of Dementia: Review. JAMA. 2019 Oct 22; 322(16):1589-1599.

Ballard C and Corbett A. Management of neuropsychiatric symptoms in people with dementia. CNS Drugs 2010; 24 (9): 729-739.

Gale SA, Acar D, Daffne KR. Dementia. The American Journal of Medicine. Volume 131, Issue 10, October 2018, Pages 1161-1169.

Alzheimer's Association: alz.org

The Association for Frontotemporal Degeneration: theaftd.org

The Lewy Body Dementia Association: lbda.org